CHAPTER 3: BILLING

OBJECTIVE:

Participants will learn the basic coding needed to successfully submit and receive appropriate payment for Medicare swing bed services for the transition to and implementation of the Swing Bed PPS (SB-PPS).

They will gain an understanding of the relationship between the swing bed assessment tool (SB-MDS) and claim coding, including the appropriate use of HIPPS codes. Participants will also learn what to do in various "special" billing scenarios, such as leave of absence (LOA) and Medicare as secondary payer (MSP).

BILLING PRINCIPLES UNDER SNF PPS

Billing guidelines for the Skilled Nursing Facility Prospective Payment System (SNF PPS) modified the existing rules in the *Skilled Nursing Facility Manual (HCFA PUB. 12)*, Section 500 – 600, to meet requirements of the Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement Act of 1999(BBRA). The BBA requires that hospital swing bed providers must be integrated into the SNF PPS at the end of the transition period for skilled nursing facilities (SNFs). This transition period ends June 30, 2002. Hospitals with swing beds will become subject to the SNF PPS on the first day of each provider's next cost report year that starts on and after July 1, 2002. **Critical Access Hospitals (CAHs) are exempt** from the SNF PPS, and will continue to be reimbursed at full cost.

PPS Payment And Billing Principles For Swing Bed Facilities

Swing Bed Reimbursement is at Full Federal SNF PPS Rate

Swing bed providers will be reimbursed on the **full Federal rate** starting with their cost reporting year beginning on or after July 1, 2002.

A new PRICER will be effective October 1st of each year

- Federal rates are modified
- Wage indexes are modified

Claim Coding Requirements That Remain Unchanged By The Swing Bed Final Rule

- HCFA 1450 claims are submitted to the Fiscal Intermediary (FI) on a 30-day schedule (monthly billing)

Traditional Claim Coding Requirements Unchanged by PPS

- Part A claims must be submitted in sequential order per each admission date, including no-pay discharge
- Maximum number of covered Part A SNF days in a benefit period is 100
- Field assignments on HCFA 1450 have not been modified in length
- HCPCS are not required on Part A claims for ancillary services

When a beneficiary is no longer covered by SNF Part A benefits, inpatient hospital Part B claims may be submitted to the FI for ancillary services per the *Hospital Manual (HCFA. Pub 10) section 228*.

- The **beneficiary will remain a patient in the swing bed** unless discharged, transferred to another SNF or requires a transfer back to the hospital at an **acute** level of care

SNF PPS Coding Requirements

New PPS Required Billing Codes

- Revenue code 0022 for each assessment affecting the billing period
- HIPPS (health insurance prospective payment) code in field locator (FL) 44
- Assessment Reference Date (ARD) of the MDS in FL 45
- Number of covered days (units) in FL 46 for each HIPPS code billed
- Accommodation information (revenue code + rate x days =charges)

FACTORS WHICH AFFECT THE BILLING OF SNF PPS CLAIMS

Relationship Between The Assessment And The Claim

SNF PPS establishes a schedule of Medicare assessments. The schedule is followed throughout a beneficiary's stay and is interrupted only by discharge, a change in level of care or the end of technical eligibility. The Medicare assessment chart indicates the **maximum** number of days that can be billed per each assessment. Swing bed facilities must follow this schedule after their start date of SB-PPS.

Timing Of The Assessments

Beginning a Medicare Assessment Schedule

An assessment schedule for each eligible Medicare resident begins:

- On admission
- On re-admission
- On day one of Medicare coverage (for example, following an MSP period, following a "cut" period of less than 30 days, or following a **physician's hold period or due to medical predictability**)

Explanation of Medical Predictability

"Medical predictability" refers to the delay of a SNF or swing bed admission because the beneficiary 's condition makes it medically inappropriate to begin an active course of treatment within 30 days of his or her hospital discharge.

Medical Predictability and the Medicare Assessment Schedule

- A physician must attest to the delay in swing bed services upon hospital discharge and note the "predictable" time for the beneficiary to begin skilled services

- This permits admission to the swing bed (or the start of covered care) to exceed the normal 30-day transfer requirement

- If the beneficiary is admitted and can be covered for clinical reasons other than a therapy program, the clinical staff must make the coverage decision

- If the beneficiary is admitted for the sole purpose of a therapy program and has no other clinical reasons for Medicare coverage, the days following admission are non-covered until the period of "medical predictability" ends

    - Start the MDS schedule with a 5-day assessment at the end of the "medical predictability" period

    - A non-covered claim for dates of service before day one of Medicare would be required to meet the sequential claims processing edits

Example #1 of Medical Predictability

A beneficiary with a fractured hip was discharged to home on 07/25/02 in a body cast, along with a written order from the physician to delay a swing bed admission until 09/10/02. At that time, the beneficiary was admitted to the swing bed for a therapy program. The beneficiary would be eligible for a "covered" admission more than 30 days from the hospital discharge.

    - The admission claim would have to have to include **condition code 56**

Example #2 of Medical Predictability

A beneficiary was discharged to a swing bed directly from the hospital on 07/25/02 with a physician's written order to hold the start of a therapy program until 09/10/02. There were no other clinical needs, but the beneficiary is eligible for coverage under "presumption" until the assessment reference date of the 5-day assessment (day 6 for the purposes of this example).

- Do a 5-day assessment, and code the claim for 6 covered days, "cutting" the beneficiary on day 6 (occurrence code 22)
- Submit a non-covered claim from day 7 until 09/09/02
- Do a 5-day assessment beginning on 09/10/02 and begin billing covered care

Explanation Of Physician Hold:

In the event that the beneficiary is unable to tolerate therapy sessions, the physician can write an order to suspend therapy (not to exceed 30 days) until the beneficiary is able to resume treatments.

Physician's Hold and the Start of the Assessment Schedule

- The swing bed beneficiary will be considered non-covered, (unless other medical conditions provided reasons for coverage) until the physician writes an order to resume therapy
- Day one of Medicare is the first day that the therapy sessions resume and the swing bed should prepare a 5-day assessment according to the assessment schedule instructions

Example Of Claims Sequencing On Physical Therapy (PT) Hold

- Beneficiary is admitted on 08/02/02 and is covered based on PT services (only) until 08/09/02 when the physician issues a PT hold
    - Submit a **covered** claim for dates of service 08/02/02 - 08/09/02
    - Occurrence code 22 = 08/09/02

- Physician resumes therapy 08/24/02
    - Submit a **non-covered** claim for dates of service 8/10/02 - 08/23/02

    - Use HIPPS codes from most recent assessment for the balance of the assessment period (08/10/02 - 08/15/02)

    - Use default code AAA00 for non-covered days for which there is no new Medicare assessment (08/16/02 - 08/23/02)

    - Begin new assessment schedule on 08/24/02 with a 5-day assessment

    - Bill all subsequent claims based on a "return to skilled care" date of 08/24/02 (day one of Medicare following a "cut")

ASSESSMENT REFERENCE DATES (ARD)

The ARD is the last day of the observation period for scoring clinical information on the MDS. The date is set by the clinical staff and entered in Section 10 of the MDS For Swing Bed Hospitals (SB-MDS).

- The ARD must be accurately conveyed to the billing staff in order to correctly complete a UB-92 for the service period

Reporting The Assessment Reference Date (ARD) On The Claim

- The ARD is required on all revenue code 0022 lines except when billing the default code (AAA00)

- If no SB-MDS assessment was completed, FL 45 must be blank, and the HIPPS default code, AAA00, should be used in FL 44 if covered care was provided

ARD and the Claim
- Required on all revenue code 0022 lines, except when billing default code

- The ARD reported on the claim in FL 45 must match the date on the SB-MDS, Item 10

    - If it does not match, the FI may return the claim to the provider (on prepay demand bills) or cancel payment (on a post pay review)

    - Failure to code this date correctly results in an improperly billed claim and no Medicare payment may be made

The Regular Assessment Schedule And Billable Days For Resident With Full Benefits In An Uninterrupted Stay

Day 5 Assessment: Use assessment window chart from the Program Memorandum

MEDICARE ASSESSMENT SCHEDULE FOR SWING BED FACILITIES

Medicare MDS Assessment Type	Reason for Assessment (MDS Item 11b code)	Assessment Reference Date * (based on start of Part A stay)	Assessment Reference Date Grace Days	Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5-day	1	1 - 5**	6 - 8**	14	1 - 14
14-day	7	11 - 14	15 - 19	16	15 - 30
30-day	2	21 - 29	30 - 34	30	31 - 60
60-day	3	50 - 59	60 - 64	30	61 - 90
90-day	4	80 - 89	90 - 94	10	91 - 100

Day 5 assessment

Provides a billing code for days 1 – 14

Day 14 assessment
Provides a billing code for days 15 – 30

Day 30 assessment
Provides a billing code for days 31 – 60

Day 60 assessment
Provides a billing code for days 61 – 90

Day 90 assessment
Provides a billing code for days 91 – 100

Correct Coding Of Claims Based On Payment Schedule

Billing the Payment Blocks

- Bills must be filed on a monthly basis.
- Bill all the covered days associated with each revenue code 0022 payment period (i.e., bill up to 14 covered days on the 0022 line for the 5-day assessment) unless one of the following applies:
    - Benefits exhaust
    - Patient discharges/dies/transfers
    - There is a change in level of care to non-skilled
    - There is a change in medical condition requiring an OMRA or Change in Condition Assessment (CCA)
- The HIPPS code for revenue code 0022 line changes at the start of each payment block.
    - Even if the medical group (RUG-III score) remains the same from one assessment to the next, **the ARD and the assessment indicator will change with each new assessment**

      For example: the HIPPS code from the 5 day assessment used to bill days 1 - 14 would not be the same as the HIPPS code from the 14 day assessment used to bill days 15 - 30
- **OMRA** or **Change in Condition Assessment** (CCA), as indicated by the HIPPS code in FL 44 may be used to change the RUG-III payment rate on either:
    - The **ARD of the special assessment or** on the **first day of the payment period**, if the ARD is on a "**grace day**"
        - Use the proper assessment indicator to reflect which off-cycle assessment is being billed

The assessment schedule *starts over* for beneficiaries who are readmitted or who return to skilled care following a "cut" (when Medicare is discontinued because the beneficiary no longer meets medical coverage criteria)

- When the schedule starts over, the benefit period does not start anew, unless there has been a break in spell of illness

- If the beneficiary's period of non-coverage exceeds 30 days, you may not reinstate Medicare coverage unless the beneficiary has a new 3-day qualifying hospital stay

ASSESSMENT INDICATORS

Assessment Indicators

There are 23 assessment indicators for swing bed claims which define the type of Medicare assessment completed (see charts on next two pages) including five new codes that become effective **July 1, 2002. (NOTE: The new assessment indicators will apply to SNFs as well as to swing beds.)**

Assessment indicators must accurately reflect which assessment is being used to bill the RUG-III group for Medicare reimbursement. The assessment indicator will validate the **type of assessment and the length of time (days) allowed for payment** under SB-PPS for that assessment.

HIPPS ASSESSMENT INDICATORS/ASSESSMENT TYPE ASSESSMENT INDICATORS

The HIPPS codes established by CMS contains a three position alpha code to represent the RUG-III of the SNF resident plus a 2-position assessment indicator to indicate which assessment was completed. Together they make up the 5-position HIPPS code for the purpose of billing Part A covered days to the Fiscal Intermediary.

Each of the 23 assessment indicators refers to a specific assessment as explained in the following table.

TABLE 1

RUG-III GROUP CODES
AAA (the default code)
BA1, BA2, BB1, BB2
CA1, CA2, CB1, CB2, CC1, CC2
IA1, IA2, IB1, IB2
PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
RHA, RHB, RHC, RLA, RLB, RMA, RMB, RMC, RUA, RUB, RUC, RVA, RVB, RVC
SE1, SE2, SE3, SSA, SSB, SSC

TABLE 2

HIPPS MODIFIERS/ASSESSMENT TYPE INDICATORS

Basic Assessments

01 5-day Medicare-required assessment
02 30-day Medicare-required assessment
03 60-day Medicare-required assessment
04 90-day Medicare-required assessment
05 Readmission/Return Medicare-required assessment
07 14-day Medicare-required assessment
08 Off-cycle other Medicare-required assessment (OMRA)
30 Off-cycle swing bed change in clinical status (outside assessment window)

Replacement Assessments -Change in Clinical Status

32 Swing bed change in clinical status replaces 30-day Medicare-required assessment
33 Swing bed change in clinical status replaces 60-day Medicare-required assessment
34 Swing bed change in clinical status replaces 90-day Medicare-required assessment
35 Swing bed change in clinical status replaces a readmission/return Medicare-required assessment
37 Swing bed change in clinical status replaces 14-day Medicare-required assessment

NOTE: We have not provided a code for a change in clinical status replacing the initial 5-day Medicare-required assessment. If the change in clinical status occurs after the initial 5-day assessment has been completed (i.e., between days 1-8), and before the assessment window for the 14-day assessment, it will be considered an off-cycle change in clinical status, and the HIPPS code will be coded as 30.

Replacement Assessments: Combined OMRA and Change in Clinical Status

When billing for swing bed services, there is no need to differentiate between an OMRA and an OMRA that is also a change in clinical status. For any assessment that meets both the OMRA and clinical change criteria, use the appropriate OMRA assessment indicator.

18 OMRA only or OMRA and change in clinical status replaces 5-day assessment
28 OMRA only or OMRA and change in clinical status replaces 30-day assessment
38 OMRA only or OMRA and change in clinical status replaces 60-day assessment
48 OMRA only or OMRA and change in clinical status replaces 90-day assessment
78 OMRA only or OMRA and change in clinical status replaces 14-day assessment

Special Payment Situations -New Assessment Indicator Codes Effective July 1, 2002

In some situations, beneficiaries may change payor source after admission to the swing bed, but fail to notify the provider in a timely manner; e.g., disenrollment from an HMO, disenrollment from a hospice, change in Medicare payor status from secondary to primary, etc. In those situations, the provider may not have completed the MDS assessments needed for Medicare billing. New assessment indicator codes have been established for these special payment situations. Claims processing instructions are being developed and will be issued separately.

19 Special payment situation 5-day assessment
29 Special payment situation 30-day assessment
39 Special payment situation 60-day assessment
49 Special payment situation 90-day assessment
79 Special payment situation 14-day assessment

Default Code - No Assessment Completed
00 Default code (No assessment completed)

The use of these special payer source assessments is being defined and will be released separately.

DEFAULT CODE:

An assessment indicator is required with the use of the default code (AAA) when days are billed on the UB-92 to the Medicare FI for services which are determined to be “covered care,” but no assessment has been completed to classify the resident.

The default assessment indicator is 00. The **HIPPS code would appear as AAA00**.

Correct Claim Coding Using Assessment Indicators

The HIPPS code will be calculated by the RAVEN-SB software, and verified by CMS as part of the SB-MDS Final Validation Report.

The Raven SB-MDS grouper has been designed to **assign the correct assessment indicator** that is used for Medicare billing. Following transmission of the SB-MDS document to CMS, the validation report will be returned to the swing bed with the correct HIPPS code for UB92 claim preparation.

- The HIPPS codes for special payer situations must be assigned manually
- Any incorrectly assigned assessment indicator can result in an incorrectly billed claim
- Incorrectly billed claims will either be returned to the provider (on prepay demand bill review) or payment canceled (on postpay medical review)
- Future edits will return claims to the provider if incorrect assessment indicators are submitted

5-DAY PRESUMPTION OF COVERAGE

Billing For "Presumption Of Coverage" At Day 5 Assessment

- The SNF PPS establishes a "presumption of coverage" through the ARD of the 5-day assessment

- The clinical staff must make the coverage decision by the ARD of the 5-day assessment

- The clinical staff will determine if a notice of non-coverage if necessary

Billing Under Presumption of Coverage on the 5-day Assessment

- The clinical staff provide the billing department with the HIPPS code and dates of service that may be billed to Medicare

- If the swing bed resident is no longer receiving skilled care by the ARD of the 5-day assessment, Medicare can only be billed from the admission date through the ARD. The beneficiary would then be "cut" from coverage

    - Code the claim with Occurrence Code 22 equal to the ARD

Example 1: Patient Admitted On 07/01/02

- ARD set for 07/05/02
- RUG-III code from assessment = CC1
- Per clinical perspective, resident is no longer receiving skilled services on ARD
- Bill 5 covered days (07/01/ 02- 07/05/02)
- Occurrence Code 22 = 07/05/02

Example 2: Patient Admitted On 07/01/02

- ARD set for 07/05/02
- RUG-III code from assessment = RVB
- Beneficiary continues skilled services until discharge
- Coverage is not based on presumption, but on receipt of skilled care from admission

Claim Example: Presumption Of Coverage Until ARD Of 5-Day Assessment

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Swing Bed Claim		12345	182

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	070102	070502	5				

12 PATIENT NAME	13 PATIENT ADDRESS
GRIFFIN BARBARA	400 S. SALINA ST SYRACUSE NEW YORK 13221

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 date	18 hr	19 type	20 src	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02251925	F		0701 2002		2	4		30	12345								

32 OCCURRENCE code	date	33 OCCURRENCE CODE	DATE	34 OCCURRENCE cod	date	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
22	070502							70	062502	070102	A
											B
											C

38

	39 VALUE CODES code	amount	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES code	amount
a	09	XXXX				
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
0022		CC101	070502	5	0	00		
0120		25000		5	1250	00		
0250				1	75	00		
0270				1	15	00		
0424				1	200	00		
0001					1540	00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	XXXXXX					

57 **DUE FROM**

58 INSURED'S NAME	59 P. REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
GRIFFIN B	01	987654321A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
481									481		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date

82 ATTENDING PHYS. ID
B12345 GLIDDEN G

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS
SNF/Swing-Bed Presumption of Coverage Until ARD of 5 day Assessment

85 PROVIDER REPRESENTATIVE X 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

SEQUENCING OF CLAIMS

The facility must submit the claims in a sequence based on each admission date for a beneficiary that enters the swing bed with all 100 days of SNF benefits available **and** who meets skilled coverage guidelines until discharge/transfer, or death.

Sequencing of Claims for Continued Covered Care

Type Of Bill - Part A Swing Bed

181 -Admit to Discharge
182 - First in a Sequence, Continuing Claim
183 - Continuing Claim
184 - Discharge Claim
180 - Non-covered Claim

Examples:

If a beneficiary was admitted on 07/01/02 and discharged on 08/01/02, submit a single claim

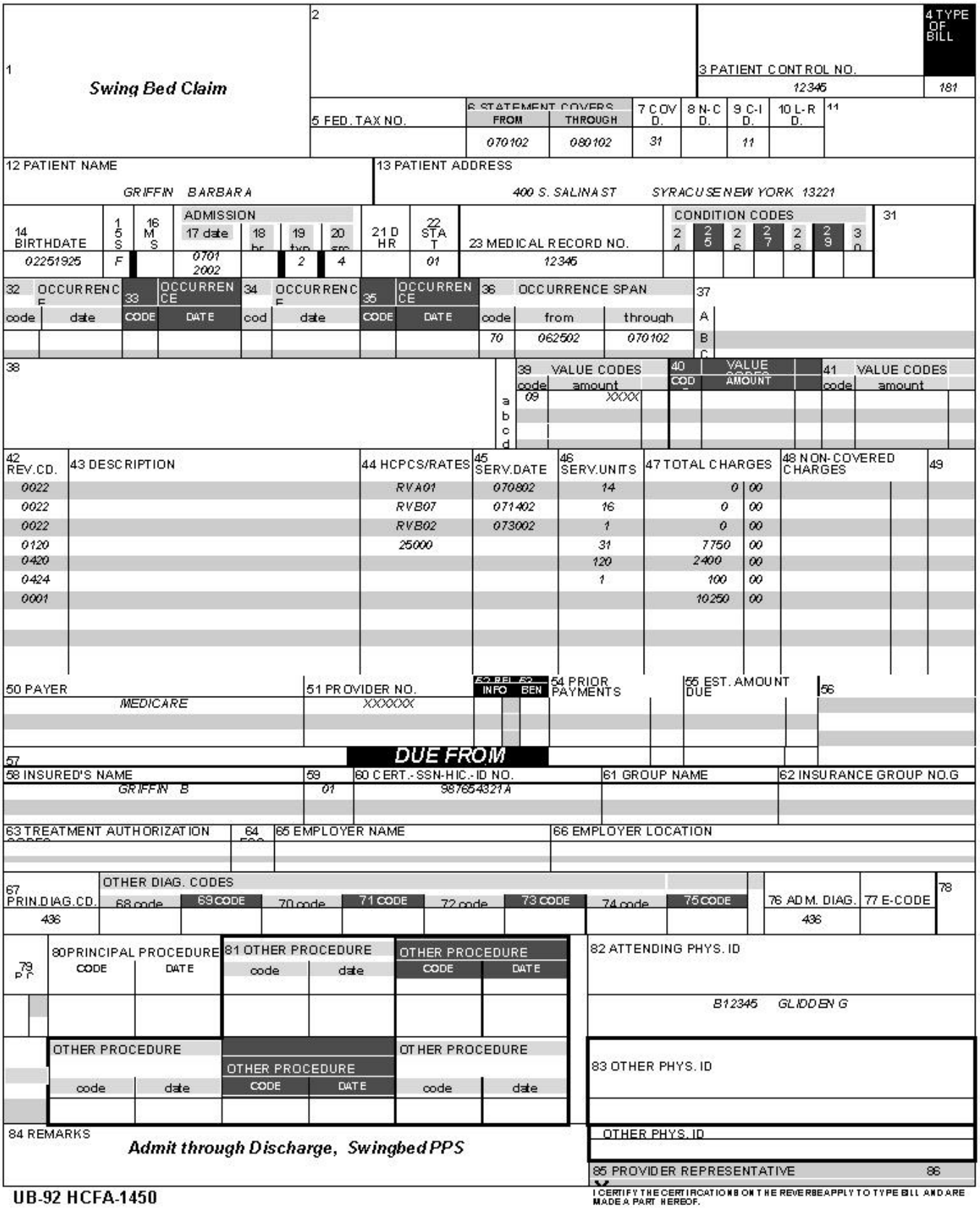
- Type of bill 181 for dates of service 07/01/02 - 08/01/02

If a beneficiary was admitted on 07/01/02 and discharged to home on 09/11/02, submit three covered claims

- Type of bill 182 for dates 07/01/02 - 07/31/02
- Type of bill 183 for dates 08/01/02 - 08/31/02
- Type of bill 184 for dates 09/01/01 - 09/11/02

If a beneficiary remains in the swing bed after Part A benefits end, a final discharge bill (type of bill 184 or 180) **must** be submitted when the resident finally leaves the facility

Claim Example: Beneficiary Receives Skilled Care From Admission To Discharge



1 *Swing Bed Claim*

2

3 PATIENT CONTROL NO. *12345*

4 TYPE OF BILL *181*

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM *070102* THROUGH *080102*

7 COV D. *31*

8 N-C D.

9 C-I D. *11*

10 L-R D.

11

12 PATIENT NAME: *GRIFFIN BARBARA*

13 PATIENT ADDRESS: *400 S. SALINA ST SYRACUSE NEW YORK 13221*

14 BIRTHDATE	15 S	16 MS	ADMISSION 17 date	18 hr	19 typ	20 src	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
02251925	*F*		*0701 2002*		*2*	*4*		*01*	*12345*		

32 OCCURRENCE code	32 OCCURRENCE date	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE cod	34 OCCURRENCE date	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN code	from	through	37
								70	*062502*	*070102*	A
											B
											C

38

	39 VALUE CODES code	amount	40 VALUE CODES COD	AMOUNT	41 VALUE CODES code	amount
a	*09*	*XXXX*				
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		*RVA01*	*070802*	*14*	*0 00*		
0022		*RVB07*	*071402*	*16*	*0 00*		
0022		*RVB02*	*073002*	*1*	*0 00*		
0120		*25000*		*31*	*7750 00*		
0420				*120*	*2400 00*		
0424				*1*	*100 00*		
0001					*10250 00*		

50 PAYER: *MEDICARE*

51 PROVIDER NO.: *XXXXXX*

52 REL. BEN. INFO

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56

57 **DUE FROM**

58 INSURED'S NAME: *GRIFFIN B*

59 *01*

60 CERT.-SSN-HIC.-ID NO.: *987654321A*

61 GROUP NAME

62 INSURANCE GROUP NO.G

63 TREATMENT AUTHORIZATION CODES

64 ECD

65 EMPLOYER NAME

66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									*436*		

79 PP	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date

82 ATTENDING PHYS. ID: *B12345 GLIDDEN G*

83 OTHER PHYS. ID

84 REMARKS: ***Admit through Discharge, Swingbed PPS***

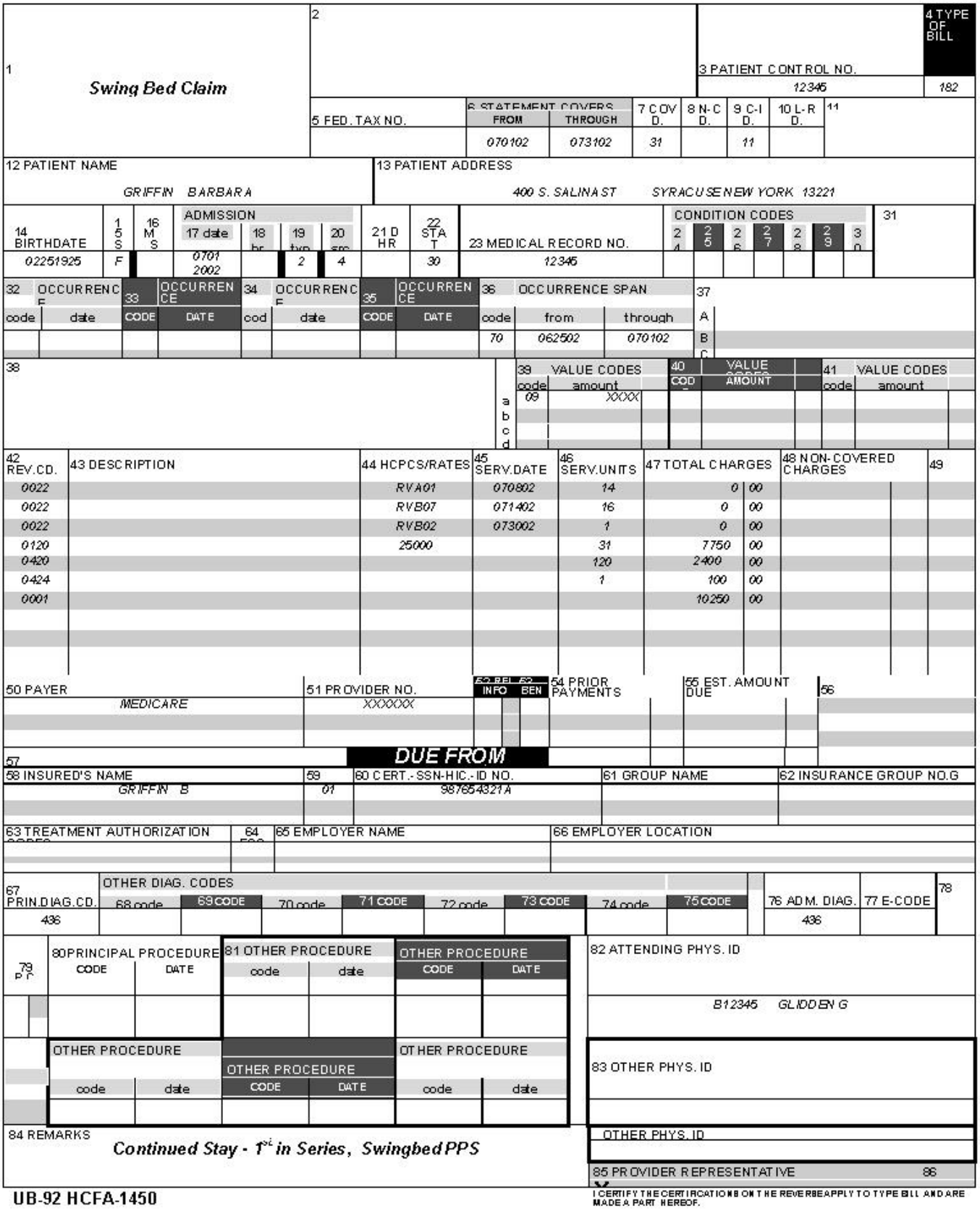
OTHER PHYS. ID

85 PROVIDER REPRESENTATIVE 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

Claim Example: Continuous Care Claim #1



1 *Swing Bed Claim*

2

3 PATIENT CONTROL NO. *12345*

4 TYPE OF BILL *182*

5 FED. TAX NO.

6 STATEMENT COVERS: FROM *070102* THROUGH *073102*

7 COV D. *31* | 8 N-C D. | 9 C-I D. *11* | 10 L-R D. | 11

12 PATIENT NAME: *GRIFFIN BARBARA*

13 PATIENT ADDRESS: *400 S. SALINA ST SYRACUSE NEW YORK 13221*

14 BIRTHDATE	15 S	16 M S	ADMISSION 17 date	18 hr	19 typ	20 src	21 D HR	22 STA T	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
02251925	*F*		*0701 2002*		*2*	*4*		*30*	*12345*		

32 OCCURRENCE code	date	33 CODE	DATE	34 OCCURRENCE cod	date	35 CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
								70	*062502*	*070102*	A B C

38

39 VALUE CODES code	amount	40 VALUE CODES COD	AMOUNT	41 VALUE CODES code	amount
09	*XXXX*				

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		*RVA01*	*070802*	*14*	*0 00*		
0022		*RVB07*	*071402*	*16*	*0 00*		
0022		*RVB02*	*073002*	*1*	*0 00*		
0120		*25000*		*31*	*7750 00*		
0420				*120*	*2400 00*		
0424				*1*	*100 00*		
0001					*10250 00*		

50 PAYER	51 PROVIDER NO.	52 REL INFO	52 REL BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	*XXXXXX*					

57 **DUE FROM**

58 INSURED'S NAME	59	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.G
GRIFFIN B	*01*	*987654321A*		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									*436*		

79 PP	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date

82 ATTENDING PHYS. ID: *B12345 GLIDDEN G*

83 OTHER PHYS. ID

OTHER PHYS. ID

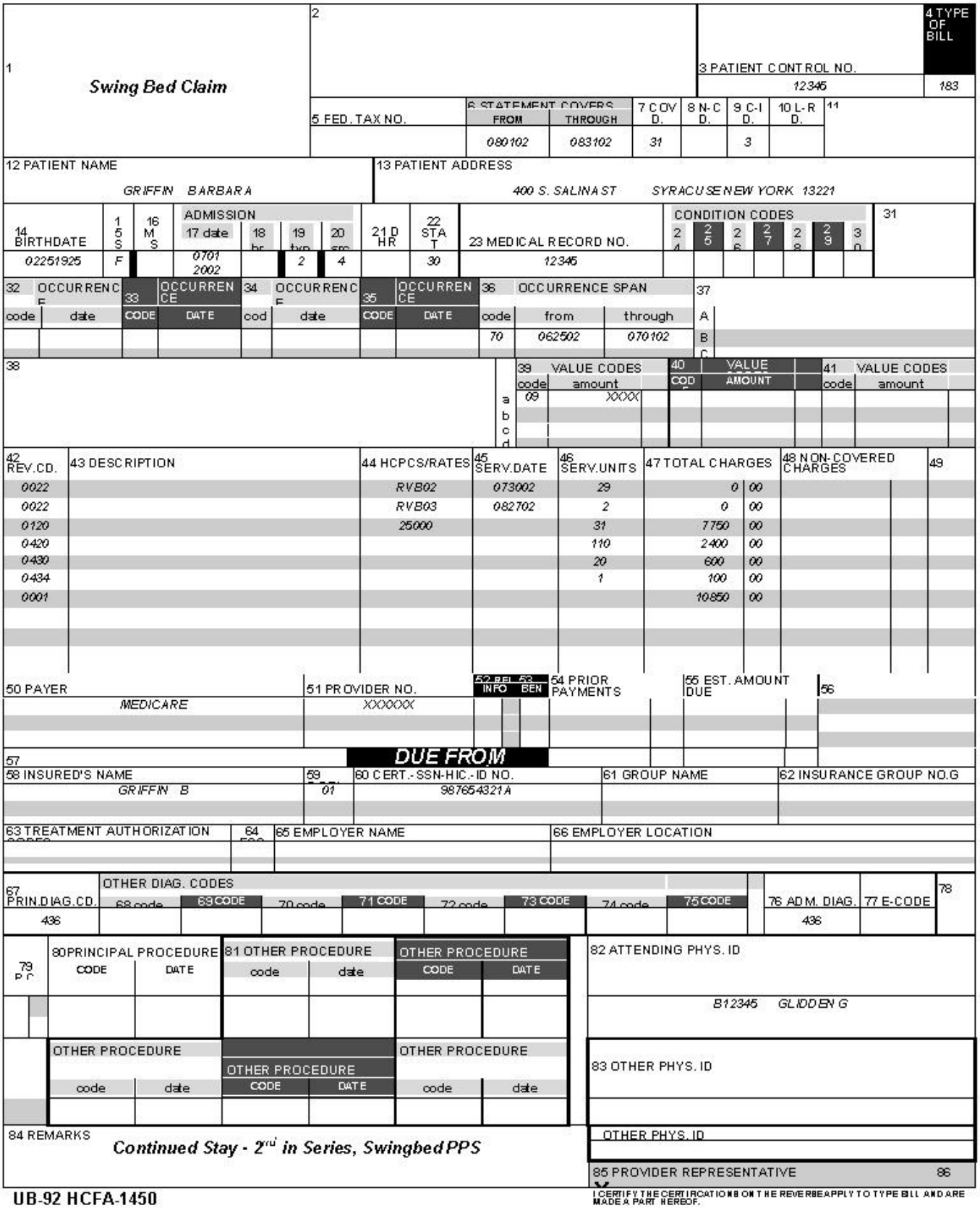
84 REMARKS: *Continued Stay - 1st in Series, Swingbed PPS*

85 PROVIDER REPRESENTATIVE 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

Claim Example: Continuous Care Claim #2



1 *Swing Bed Claim*

2

3 PATIENT CONTROL NO. *12345*

4 TYPE OF BILL *183*

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM *080102* THROUGH *083102*

7 COV D. *31*

8 N-C D.

9 C-I D. *3*

10 L-R D.

11

12 PATIENT NAME: *GRIFFIN BARBARA*

13 PATIENT ADDRESS: *400 S. SALINA ST SYRACUSE NEW YORK 13221*

14 BIRTHDATE	15 S	16 MS	ADMISSION 17 date	18 hr	19 typ	20 src	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
02251925	*F*		*0701 2002*		*2*	*4*		*30*	*12345*		

32 OCCURRENCE code	date	33 OCCURRENCE CODE	DATE	34 OCCURRENCE cod	date	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
								70	*062502*	*070102*	A B C

38

39 VALUE CODES code	amount	40 VALUE COD	AMOUNT	41 VALUE CODES code	amount
a *09*	*XXXX*				
b					
c					
d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		*RVB02*	*073002*	*29*	*0 00*		
0022		*RVB03*	*082702*	*2*	*0 00*		
0120		*25000*		*31*	*7750 00*		
0420				*110*	*2400 00*		
0430				*20*	*600 00*		
0434				*1*	*100 00*		
0001					*10850 00*		

50 PAYER	51 PROVIDER NO.	52 REL. BEN. INFO	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	*XXXXXX*				

57 **DUE FROM**

58 INSURED'S NAME	59	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.G
GRIFFIN B	*01*	*987654321A*		

63 TREATMENT AUTHORIZATION	64	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									*436*		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date

82 ATTENDING PHYS. ID: *B12345 GLIDDEN G*

83 OTHER PHYS. ID

84 REMARKS: *Continued Stay - 2nd in Series, Swingbed PPS*

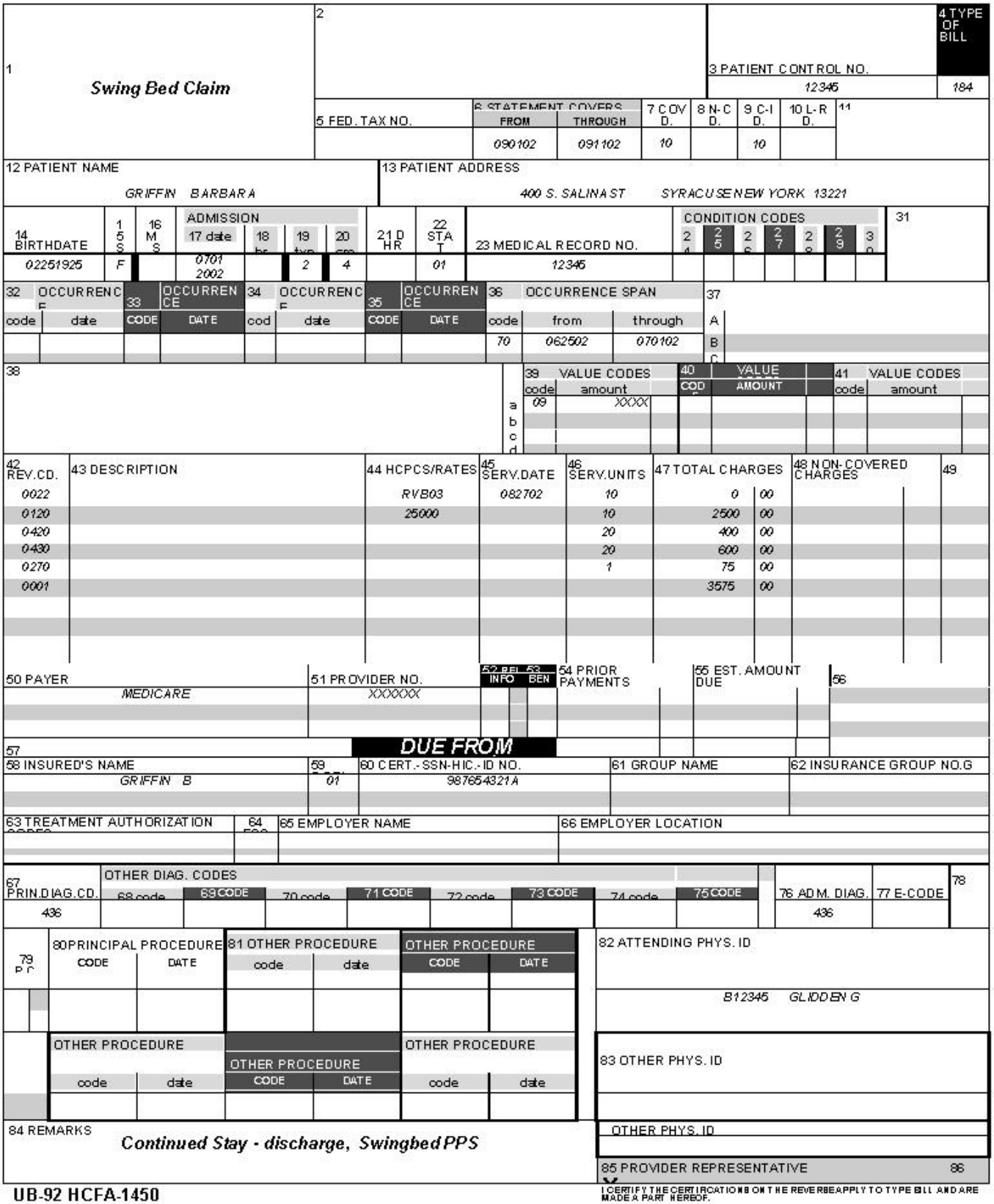
OTHER PHYS. ID

85 PROVIDER REPRESENTATIVE 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

Claim Example: Continuous Care Claim #3-Final Discharge



1 *Swing Bed Claim*

2

3 PATIENT CONTROL NO. *12345*

4 TYPE OF BILL *184*

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM *090102* THROUGH *091102*

7 COV D. *10*

8 N-C D.

9 C-I D. *10*

10 L-R D.

11

12 PATIENT NAME *GRIFFIN BARBARA*

13 PATIENT ADDRESS *400 S. SALINA ST SYRACUSE NEW YORK 13221*

14 BIRTHDATE	15 S	16 M S	ADMISSION 17 date	18 hr	19 typ	20 src	21 D HR	22 STA T	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02251925	*F*		*0701 2002*		*2*	*4*		*01*	*12345*								

32 OCCURRENCE code	date	33 OCCURRENCE CODE	DATE	34 OCCURRENCE cod	date	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
								70	*062502*	*070102*	A
											B
											C

38

	39 VALUE CODES code	amount	40 VALUE COD	AMOUNT	41 VALUE CODES code	amount
a	*09*	*XXXX*				
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
0022		*RVB03*	*082702*	*10*	*0*	*00*		
0120		*25000*		*10*	*2500*	*00*		
0420				*20*	*400*	*00*		
0430				*20*	*600*	*00*		
0270				*1*	*75*	*00*		
0001					*3575*	*00*		

50 PAYER	51 PROVIDER NO.	52 REL. INFO	52 BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	*XXXXXX*					

57 **DUE FROM**

58 INSURED'S NAME	59	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.G
GRIFFIN B	*01*	*987654321A*		

63 TREATMENT AUTHORIZATION	64	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									*436*		

79 P C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date

82 ATTENDING PHYS. ID *B12345 GLIDDEN G*

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS *Continued Stay - discharge, Swingbed PPS*

85 PROVIDER REPRESENTATIVE 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

ENDING COVERAGE IN A PART A STAY

The clinical staff of a swing bed must continually monitor the Medicare beneficiaries to determine if they meet level of care guidelines for payment.

Coding for "Cut" Claims

If a beneficiary no longer meets the "skilled care" criteria for coverage in a swing bed, the beneficiary should be issued a notice of non-coverage and be **"cut"** from Medicare coverage.

- Demand bill requests may follow a notice of non-coverage, so it is advisable (but not required) to **submit claims through the last *covered* day**
- If bills are submitted for an entire calendar month including covered and non-covered days, all span codes and non-covered ancillary services must be correctly coded on the claim
- The time required for subsequent demand bill review will tie up the payment of the covered portion of a month
- The last covered day must be indicated by occurrence code 22 and date
- Occurrence code 22 is the **only code** which will set a "counter" at CWF to determine if the beneficiary meets the 60 days "non-skilled" criteria for break in spell

Claim Example Of A "Cut" Claim Following The End Of Skilled Care

1 *Swing Bed Claim*	2	3 PATIENT CONTROL NO. 12346	4 TYPE OF BILL 182

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	090102	091002	10				

12 PATIENT NAME	13 PATIENT ADDRESS
STAFFORD, ROSEMARY	400 S. SALINA ST SYRACUSE NEW YORK 13221

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 date	18 hr	19 type	20 src	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
10091925	F		0901 2002		2	4		30	12346								

32 OCCURRENCE code	date	33 OCCURRENCE CODE	DATE	34 OCCURRENCE code	date	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
22	091002							70	082502	090102	A
											B
											C

38

	39 VALUE CODES code	amount	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES code	amount
a						
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
0022		RVB01	090802	10	0	00		
0120		25000		10	2500	00		
0420				20	400	00		
0424				1	200	00		
0274				1	75	00		
0001					3575	00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	XXXXXX					

57 **DUE FROM**

58 INSURED'S NAME	59 P. REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
GRIFFIN B	01	987654321A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									436		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
							B12345 GLIDDEN G
	OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date	83 OTHER PHYS. ID
							OTHER PHYS. ID

84 REMARKS *"Cut" Claim, Swingbed PPS*

85 PROVIDER REPRESENTATIVE X 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

DEMAND BILLS

Any time a Medicare beneficiary requests that a demand bills be sent, the swing bed must comply by sending it to the FI. The beneficiary makes this request by marking the box on the notice of non-coverage that requires a claim to be billed.

Demand bills must be submitted even in cases of technical ineligibility. However, the FI will handle those cases differently because no medical review is necessary when the patient is not technically eligible for Part A reimbursement.

Coding for Demand Bills

Claim Coding For Demand Bills

- Use a valid HIPPS code on the claim (use default code AAA00 **only** in the absence of a valid MDS)
- For swing bed residents that have Part A days available to use, there **must be a separate HIPPS code on the claim for each block of time (i.e., payment period) that would have been represented by a new Medicare required assessment**
    - For a technically ineligible beneficiary (no qualifying hospital stay, benefits exhaust, etc.), you may use the default code AAA00

Use Default Code **Only** When **No** MDS Was Completed

- The minimum requirement is to bill from the first non-covered day to the end of the billing period
- Submit the claim with the following data elements specific to demand bills:
    - Non-covered days in FL 8
    - Condition code 20 in FL 24
    - **Total days** per SB-MDS on revenue code 0022
    - Total **covered** days per SB-MDS on revenue code 0022 line=0
    - Total **covered** accommodation days = 0
    - All ancillary services reported as non-covered charges

- Do not attach medical information to the paper claim or enter clinical information electronic claims record

Demand Bills Following MR Review To Uphold Swing Bed Decision Of Non-coverage

Billing When FI Upholds Swing Bed Decision of Non-coverage

Beneficiary Liability Assigned

- Beneficiary must make payment for the continued stay even if an appeal is filed
- Subsequent requests for demand bills must be sent and the swing bed facility should notify the FI if the patient is now technically ineligible due to 30 days of non-coverage. (Use Remarks Screen/Field)
- If the number of non-covered days on the previous demand bill is less than 30 days, the subsequent demand bill must be reviewed according to normal procedure for technically qualified resident

Provider Liability Assigned

- Provider may not bill the resident for dates of provider liability
- Decision may be appealed

Demand Bills Following MR Review To Overturn And Pay Swing Bed For Covered Care On A Demand Bill

- Submit subsequent claims as non-covered following all the billing requirements (HIPPS Codes, ARD, etc.).
- For technically eligible residents (with benefit days available), the swing bed hospital may not bill the resident until the medical review decision is made.

Claim Example: Demand Bill

Field	Value
1	Swing Bed Claim
2	
3 PATIENT CONTROL NO.	12345
4 TYPE OF BILL	183
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM	091102
6 STATEMENT COVERS PERIOD THROUGH	093002
7 COV D.	
8 N-C D.	20
9 C-I D.	
10 L-R D.	
11	
12 PATIENT NAME	STAFFORD, ROSEMARY
13 PATIENT ADDRESS	400 S. SALINA ST SYRACUSE NEW YORK 13221
14 BIRTHDATE	10091925
15 SEX	F
16 MS	
ADMISSION 17 date	0901 2002
18 hr	
19 type	2
20 src	4
21 D HR	
22 STAT	30
23 MEDICAL RECORD NO.	12345
CONDITION CODES 24	20
25–30	
31	

32 OCCURRENCE code	date	33 OCCURRENCE CODE	DATE	34 OCCURRENCE code	date	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
								70	082502	090102	

38

	39 VALUE CODES code	amount	40 VALUE CODES code	amount	41 VALUE CODES code	amount
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		RVB01	090802	4	0 00		
0022		AAA00		16	0 00		
0120		25000		20	5000 00	5000 00	
0001				20	5000 00	5000 00	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	XXXXXX					

57 DUE FROM

58 INSURED'S NAME	59 P. REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
GRIFFIN B	01	987654321A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									436		

79 P.C. | 80 PRINCIPAL PROCEDURE code / date | 81 OTHER PROCEDURE code / date | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE code / date | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE code / date

82 ATTENDING PHYS. ID: B12345 GLIDDEN G

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS: **Demand Claim - Therapy Services End, No other Clinical Care**

85 PROVIDER REPRESENTATIVE X | 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

LATE OR MISSED ASSESSMENTS

Both SNF PPS and SB-PPS allow for a window of time in which the assessment reference date (ARD) is set. The regulation includes the use of grace days when setting the ARD of each swing bed assessment without a penalty.

Late Days Allowed for Completing the Assessments
- Use of default HIPPS code

- When the ARD is set late, claims must be billed at the default rate (AAA00) for all days until an ARD is established

- Using the default code (AAA00) to bill covered days signifies that the swing bed **facility considers the resident to be at a skilled level of care**, but no assessment was completed to classify him/her into a RUG-III group

Billing Claims For Late Assessments

- The default code (AAA00) must be used in all cases when the ARD of the required assessment was not set timely
- The default code (AAA00) is applied to all of the days until the ARD is set for the late assessment
- The HIPPS code from late assessment becomes effective with the ARD of that late assessment and is valid only until the end of the SB-PPS payment block per the assessment table
- Late assessments never replace the next regularly scheduled assessment

Example:
- Patient admitted 12/1/02
- ARD for 14 day should be set between 12/11/02 – 12/19/02
- ARD set on 12/23/02
- Bill default (AAA00) 12/15/02 – 12/22/02
- Bill HIPPS code from late assessment for days 12/23/02 – 12/30/02
- Assessment indicator is 07 (assessment indicator is always for the assessment which is currently due)
- 30-day assessment is due on schedule

Claim Example: Use Of Default Code When ARD Is Set Late

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Swing Bed Claim		*12345*	*182*

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	070102	*073102*	*31*		*11*		

12 PATIENT NAME	13 PATIENT ADDRESS
GRIFFIN BARBARA	*400 S. SALINA ST SYRACUSE NEW YORK 13221*

14 BIRTHDATE	15 S	16 M S	ADMISSION 17 date	18 hr	19 typ	20 src	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
02251925	*F*		*0701 2002*		*2*	*4*		*30*	*12345*		

32 OCCURRENCE code	date	33 OCCURRENCE CODE	DATE	34 OCCURRENCE cod	date	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
								70	*062502*	*070102*	A B C

38	39 VALUE CODES code	amount	40 VALUE CODES COD	AMOUNT	41 VALUE CODES code	amount
	a *09*	*XXXX*				
	b					
	c					
	d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		*AAA00*		*0*	*0 00*		
0022		*RVA01*	*071002*	*5*	*0 00*		
0022		*RVB07*	*071402*	*16*	*0 00*		
0022		*RVB02*	*073002*	*1*	*0 00*		
0120		*25000*		*31*	*7750 00*		
0420				*120*	*2400 00*		
0424				*1*	*200 00*		
0001					*10350 00*		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASSIGN BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	*XXXXXX*					

57 **DUE FROM**

58 INSURED'S NAME	59	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.G
GRIFFIN B	*01*	*987654321A*		

63 TREATMENT AUTHORIZATION	64	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									*436*		

79 P C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
							B12345 GLIDDEN G

OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date	83 OTHER PHYS. ID

84 REMARKS

SNF/Swing-Bed Claim - USE OF DEFAULT CODE WHEN FACILITY FAILED TO SET ARD TIMELY

OTHER PHYS. ID

85 PROVIDER REPRESENTATIVE 86

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SPECIALITY CLAIMS BILLING

Residents Not Affected By The Swing Bed PPS Assessment Schedule

SB-PPS regulations do not apply to all Medicare beneficiaries in a swing bed. When it is determined that the beneficiary's care is reimbursed under a different payment source, the PPS assessment schedule does not need to be followed.

Medicare Beneficiaries Enrolled In Risk HMOs

SB-PPS Impact on HMO Beneficiaries
- Risk HMOs
- Cost HMOs

A Medicare beneficiary in a **Risk** HMO (Option C) will be covered (or not) based on the policies of the insurer; however, the HMO may **never** offer the beneficiary anything less than what is provided to the Medicare fee-for-service beneficiary.

- Bill the HMO according to contract terms
- The assessment schedule does not need to be followed for Medicare billing purposes
- The HCFA 1450 **must** be submitted to the FI for benefit management (the default code AAA00 may be used) with condition code 04.
    - If the HMO paid the claim, submit the days as "**covered**"
    - If the HMO denied the claim, submit the days as "**non-covered**"
- Residents receiving HMO denials may file an appeal with the HMO. **Do not send a demand bill to the FI.**

Medicare Beneficiaries Enrolled In Cost HMOs

A Medicare beneficiary in a **Cost** HMO (Option 1) has a choice of where to receive services. All claims for Cost HMO beneficiaries in a Medicare certified swing bed are **sent to the FI for processing for payment and benefit utilization.**

- Follow the SB-PPS assessment schedule
- Submit a HCFA-1450 to the FI using the HIPPS code for each required Medicare assessment

Claim Example: Risk HMO Utilization (Services Covered By The HMO)

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Swing Bed Claim		12345	182

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	100102	103102	31		11		

12 PATIENT NAME	13 PATIENT ADDRESS
GRIFFIN BARBARA	400 S. SALINA ST SYRACUSE NEW YORK 13221

14 BIRTHDATE	15 S	16 M S	ADMISSION 17 date	18 hr	19 typ	20 src	21 D HR	22 STA T	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
02251925	F		0701 2002		2	4		30	12345	04	

32 OCCURRENCE code	date	33 CODE	OCCURRENCE DATE	34 OCCURRENCE cod	date	35 CODE	OCCURRENCE DATE	36 OCCURRENCE SPAN code	from	through	37
								70	092502	100102	A B C

38	39 VALUE CODES code	amount	40 VALUE CODES COD	AMOUNT	41 VALUE CODES code	amount
	a 09	XXXX				
	b					
	c					
	d					

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		RVA01	100802	14	0 00		
0022		RVB07	101402	16	0 00		
0022		RVB02	103002	1	0 00		
0120		25000		31	7750 00		
0420				120	2400 00		
0424				1	100 00		
0001					10250 00		

50 PAYER	51 PROVIDER NO.	52 REL. BEN. INFO	BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	XXXXXX					

57 **DUE FROM**

58 INSURED'S NAME	59	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.G
GRIFFIN B	01	987654321A		

63 TREATMENT AUTHORIZATION	64	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									436		

79 PT	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
							B12345 GLIDDEN G

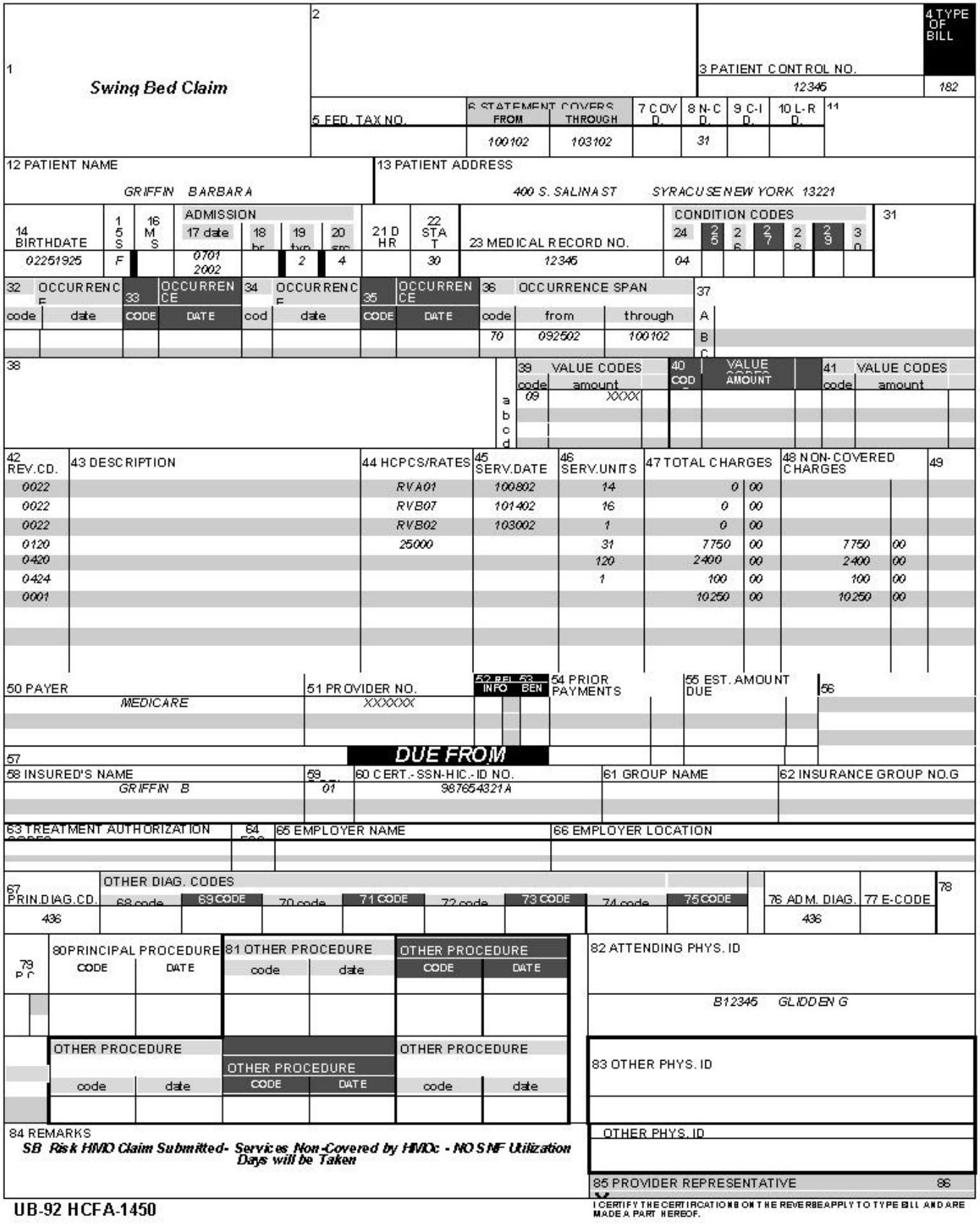
OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
SB Risk HMO Claim Submitted for Benefit Utilization -	
	85 PROVIDER REPRESENTATIVE 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Claim Example: Non-covered Risk HMO



1 *Swing Bed Claim*

2

3 PATIENT CONTROL NO. *12345*

4 TYPE OF BILL *182*

5 FED. TAX NO.

6 STATEMENT COVERS FROM *100102* THROUGH *103102*

7 COV D. | 8 N-C D. *31* | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME *GRIFFIN BARBARA*

13 PATIENT ADDRESS *400 S. SALINA ST SYRACUSE NEW YORK 13221*

14 BIRTHDATE	15 S	16 MS	ADMISSION 17 date	18 hr	19 typ	20 src	21 DHR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
02251925	*F*		*0701 2002*		*2*	*4*		*30*	*12345*	*04*	

32 OCCURRENCE code	date	33 CODE	DATE	34 OCCURRENCE cod	date	35 CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
								70	*092502*	*100102*	A B C

38

39 VALUE CODES code	amount	40 COD	VALUE AMOUNT	41 VALUE CODES code	amount
09	*XXXX*				

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		*RVA01*	*100802*	*14*	*0 00*		
0022		*RVB07*	*101402*	*16*	*0 00*		
0022		*RVB02*	*103002*	*1*	*0 00*		
0120		*25000*		*31*	*7750 00*	*7750 00*	
0420				*120*	*2400 00*	*2400 00*	
0424				*1*	*100 00*	*100 00*	
0001					*10250 00*	*10250 00*	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	*XXXXXX*					

57 **DUE FROM**

58 INSURED'S NAME	59	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.G
GRIFFIN B	*01*	*987654321A*		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									*436*		

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date

82 ATTENDING PHYS. ID *B12345 GLIDDEN G*

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS *SB Risk HMO Claim Submitted- Services Non-Covered by HMOc - NO SNF Utilization Days will be Taken*

85 PROVIDER REPRESENTATIVE 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

SB-PPS Impact on Hospice Beneficiaries

- Hospice beneficiaries admitted to swing bed for their terminal Illness
- Hospice beneficiaries admitted to a swing bed for a non-hospice related illness

Medicare Beneficiaries Enrolled In Hospice

Medicare beneficiaries enrolled in the hospice program who are admitted to the swing bed facility for their terminal illness are not covered by the inpatient Part A SNF benefit.

- SB-MDS assessments are not required, but may be completed at the facility's option for any patient in a Medicare or Medicaid-certified bed
- No discharge claim is necessary
- Be alert for beneficiaries who opt-out of the hospice program and revert to traditional Medicare coverage because SB-PPS assessment schedules would then apply

Medicare beneficiaries enrolled in hospice who are admitted to a swing bed facility for a condition **unrelated to their terminal illness *are* governed by SB-PPS regulations.**

- Follow the SB-PPS assessment schedule
- Bill covered claims with valid HIPPS codes from Medicare required assessments
    - Condition code 07 must be present on the claim
    - Utilization days will be taken

Claim Example: Hospice Claim - Services Not Related To Terminal Illness

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Swing Bed Claim		*12345*	*182*

5 FED. TAX NO.	6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	070102	*073102*	*31*		*11*		

12 PATIENT NAME	13 PATIENT ADDRESS
GRIFFIN BARBARA	*400 S. SALINA ST SYRACUSE NEW YORK 13221*

14 BIRTHDATE	15 S	16 MS	ADMISSION 17 date	18 hr	19 typ	20 src	21 DHR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02251925	*F*		*0701 2002*		*2*	*4*		*30*	*12345*	*07*							

32 OCCURRENCE code	date	33 CODE	DATE	34 OCCURRENCE cod	date	35 CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
								70	*062502*	*070102*	A B C

38		39 VALUE CODES code	amount	40 VALUE COD	AMOUNT	41 VALUE CODES code	amount
	a	*09*	*XXXX*				
	b						
	c						
	d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
0022		*RVA01*	*070802*	*14*	*0*	*00*		
0022		*RVB07*	*071402*	*16*	*0*	*00*		
0022		*RVB02*	*073002*	*1*	*0*	*00*		
0120		*25000*		*31*	*7750*	*00*		
0420				*120*	*2400*	*00*		
0424				*110*	*100*	*00*		
0001					*10250*	*00*		

50 PAYER	51 PROVIDER NO.	52 REL INFO	52 REL BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	*XXXXXX*					

57 **DUE FROM**

58 INSURED'S NAME	59	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.G
GRIFFIN B	*01*	*987654321A*		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									*436*		

79 PT	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
							B12345 GLIDDEN G
	OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date	83 OTHER PHYS. ID

84 REMARKS	OTHER PHYS. ID
SB Hospice Claim - Services NOT Related to Terminal illness	
	85 PROVIDER REPRESENTATIVE 86

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Beneficiaries With Other Insurance Coverage

Medicare regulations require swing bed facilities to follow certain admission practices, which include a survey for coverage by another insurer. If another payer is responsible for the payment of the stay, the swing bed will bill the other payer according to the rules of that insurer.

Impact of Other Insurance on SB-PPS Assessment Schedule
- MSP categories
- Beginning an assessment schedule when other insurance ends or denies
- Submission of MSP claims

Medicare Secondary Payer (MSP) rules will affect the use of the SB-MDS assessment schedule and use of RUG-III codes.

Eight Categories of MSP Coverage

- Working Aged
- ESRD
- Auto/No Fault
- Liability
- Workers Compensation
- Disability
- Federal Black Lung
- VA Benefits

When Assessments Are Done Related To MSP

When a specific time period is guaranteed by another payer (usually by, but not limited to, an employer group health plan), the assessment schedule begins when the primary payer's coverage ends.

When the other payer's covered period is indefinite in the amount of days to be paid, it is ***recommended*** that you follow the assessment schedule from day of admission. This so that the facility has a valid HIPPS code with which to bill Medicare in the event the other payer retracts coverage.

Billing Claims During A MSP Period

All Part A MSP claims must be submitted to the FI to satisfy the sequential claims processing requirements prior to billing Medicare days

Coding for MSP Claims

- Bill claims with covered days and charges
- Use condition code 77 if payment is accepted as 'payment in full'
- SB-PPS coding must be present on the claim including HIPPS codes and ARD
- Default code AAA00 may be used if no Medicare secondary payment is sought
- All applicable MSP billing requirements must be met

Billing Claims After Other Insurance Ends

When to Begin a Medicare Assessment Schedule

- Part A Medicare primary claims follow the MSP period if the beneficiary continues to meet skilled level of care criteria
- Begin the SB-MDS assessment schedule on the first day that Medicare becomes primary
    - First assessment would use assessment indicator 01 for Medicare billing (5-day assessment) following payment by another insurer if the swing bed started the 5 day assessment on day one of Medicare
    - The first assessment would use assessment indicator 19 if the swing bed did not know the other insurance had ended and had failed to start a new 5-day assessment for Medicare billing purposes *(instructions to follow)*
- If primary insurance file is still "valid/open," code your claim with occurrence code 24 (date other insurance company denied payment) and **remarks** to explain reason other insurer is no longer paying

Claim Example: MSP

Field	Entry
1	Swing-Bed Claim
2	
3 PATIENT CONTROL NO.	12345
4 TYPE OF	181
5 FED. TAX NO.	
6 STATEMENT COVERS FROM	070102
6 STATEMENT COVERS THROUGH	073102
7 COV D	31
8 N-C D	
9 C-I D	11
10 L-R D	
11	
12 PATIENT NAME	GLIDDEN G
13 PATIENT ADDRESS	400 S SALINA ST SYRACUSE NY 13221

14	15	16 MS	ADMISSION 17 DATE	18 HR	19	20	21 D	22	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
08301925	M		07012002		2	4		30	12345	77							

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
01	062599	24	073102					70	062502	070102	A B C

38
STATE FIRM INSURANCE
100 MAIN STREET
ANYTOWN NY 12345

	39 VALUE CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	14	7500 00				
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49
0022		AAA00		30	00	00		
0120		25000		30	7500	00		
0424				1	75	00		
0420				48	1000	00		
0001					8575	00		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
STATE FIRM	XXXXXX					
MEDICARE	XXXXXX					

57 DUE FROM

58 INSURED'S NAME	59	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
GLIDDEN G	01	BB123789		
GLIDDEN g	01	987654321A		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
82110							82110				

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID B12345 GRIFFIN B

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS
SNF/Swing-Bed PPS NO-Fault Claim
NOTE - IF ASSESSMENTS WERE DONE - HIPPS CODES CAN BE USED

85 PROVIDER REPRESENTATIVE 86
X

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Leave Of Absence (LOA) Rules

Leave of absence criteria have not changed for SB-PPS. **Any time a resident does not meet midnight census taking, he is considered to be on a leave of absence.**

Leave of Absence
- Medical
- Therapeutic (social)

There are two types of LOA situations:

- Medical LOA – resident is in an emergency room of hospital, but has not been admitted as an inpatient

- Therapeutic (social) LOA – resident has gone home with family

    - Discharge tracking forms are not required by Federal regulations for the Medicare program; however, several states have requirements that the swing bed facility must follow for the SNF beneficiary in a swing bed

Coding Requirements For Leave Of Absence

- Occurrence span code 74 and applicable dates
- Revenue code 018X in FL 42
- Number of days on LOA in FL 46
- Zero (0) charges in FL 47

Effect of LOA On Benefit Days And Assessment Schedule

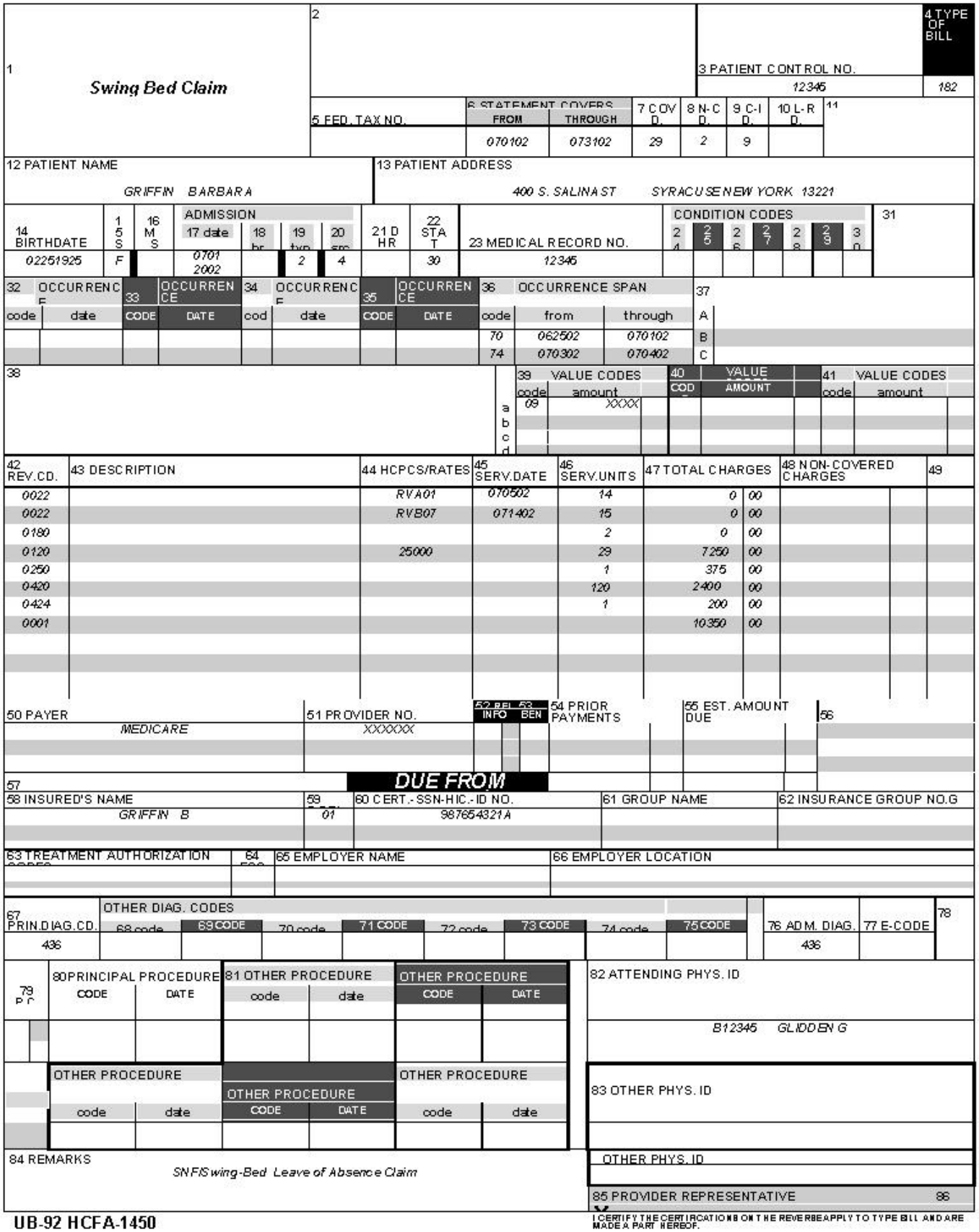
- Medicare Part A benefit days are not taken
- Do not code non-covered **charges** on LOA days revenue code 018X line
- LOA days are "skipped' on the assessment schedule
    - i.e., the assessment window and SB-PPS payment period are calculated using Medicare **covered days** rather than calendar days

Do not restart the assessment schedule when the beneficiary returns from a temporary home visit, a temporary therapeutic leave, or a hospital observational stay of less than 24 hours in which the beneficiary is not admitted for acute care hospital services or discharged from the swing bed.

The assessment schedule must be restarted when the beneficiary is in the emergency room for an observational stay of more than 24 hours, or is actually admitted for acute care hospital services or discharged from the swing bed. A Readmission/Return Assessment must be performed within 5 days of reentry to restart the Medicare assessment schedule.

- Outside services rendered to the swing bed beneficiary on a LOA day are **not** bundled to the swing bed, but **may** be billed directly to Medicare by the entity performing the service.

Claim Example: Leave Of Absence



1 *Swing Bed Claim*

2

3 PATIENT CONTROL NO. *12345*

4 TYPE OF BILL *182*

5 FED. TAX NO.

6 STATEMENT COVERS FROM *070102* THROUGH *073102*

7 COV D. *29* | 8 N-C D. *2* | 9 C-I D. *9* | 10 L-R D. | 11

12 PATIENT NAME *GRIFFIN BARBARA*

13 PATIENT ADDRESS *400 S. SALINA ST SYRACUSE NEW YORK 13221*

14 BIRTHDATE	15 S	16 M S	ADMISSION 17 date	18 hr	19 typ	20 src	21 D HR	22 STA T	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
02251925	*F*		*0701 2002*		*2*	*4*		*30*	*12345*		

32 OCCURRENCE code	32 OCCURRENCE date	33 CODE	33 OCCURRENCE DATE	34 OCCURRENCE cod	34 OCCURRENCE date	35 CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN code	from	through	37
								70	*062502*	*070102*	A
								74	*070302*	*070402*	B
											C

38

39 VALUE CODES code	amount	40 VALUE COD	AMOUNT	41 VALUE CODES code	amount
09	*XXXX*				

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0022		*RVA01*	*070502*	*14*	*0 00*		
0022		*RVB07*	*071402*	*15*	*0 00*		
0180				*2*	*0 00*		
0120		*25000*		*29*	*7250 00*		
0250				*1*	*375 00*		
0420				*120*	*2400 00*		
0424				*1*	*200 00*		
0001					*10350 00*		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	*XXXXXX*					

57 *DUE FROM*

58 INSURED'S NAME	59	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.G
GRIFFIN B	*01*	*987654321A*		

63 TREATMENT AUTHORIZATION CODES	64 ECO	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									*436*		

79 PR	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE

OTHER PROCEDURE code	date	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE code	date

82 ATTENDING PHYS. ID *B12345 GLIDDEN G*

83 OTHER PHYS. ID

84 REMARKS *SNF/Swing-Bed Leave of Absence Claim*

OTHER PHYS. ID

85 PROVIDER REPRESENTATIVE 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450

Spell of Illness
- Criteria for breaking current spell of illness
- Use of occurrence codes 22 and A3
- Discharge bills

NEW SPELL OF ILLNESS

There is no limit to the number of benefit periods a beneficiary may have as long as he/she meets the criteria for ending the **current** spell of illness.

Criteria For Breaking The Current Spell Of Illness

- 60 consecutive days facility free
- 60 consecutive days in a swing bed facility at a non-skilled level of care.

  NOTE: Since there is no Part B swing bed benefit, the non-skilled level of care would be considered as an inpatient Part B hospital stay.

CODING FOR CONTINUING STAY RESIDENTS

- Prior to benefits being exhausted, **occurrence code 22** is coded on the claim as **the last medically skilled day**
- It is a covered day on the claim (if there are still benefits available)
- It is the same day as the date of the notice of non-coverage
  - Days following occurrence code 22 are non-covered and should be submitted on a separate claim **if** the resident asks for a demand bill
- Benefits exhaust code (A3) does not impact benefit periods – it does not break spells
  - Occurrence codes 22 and A3 should not appear on the same claim

Occurrence code 22 can also be applied on a non-covered claim (after benefits exhaust) if the beneficiary drops to a "non-skilled" level of care after all 100 days have been paid

EFFECT OF DISCHARGE BILLS ON BENEFIT PERIODS

Medicare regulations outlined in Section 517 of the *HCFA Pub. 12* describe the requirement for all SNFs to **track the days beneficiaries live in a SNF**. These rules also apply to beneficiaries who remain in a swing bed following the end of Part A coverage.

- SNFs and swing bed facilities must submit a discharge bill for all residents who are enrolled in Part A (unless that resident is being covered by the Hospice)

- Discharge claims should be submitted at the time of transfer, death, discharge to home or another facility or transfer to inpatient hospital Part B status

Discharge Bills

- Claims should close a sequence (TOB 184)

- A single discharge claim is all that is required (unless you are crossing the start date of SB-PPS) from the first day of non-coverage until the date of discharge

    - Apply occurrence code 22 and date to the discharge claim if a change to non-skilled level of care has occurred since the last covered day

    - Do not apply occurrence code 22 to the discharge claim if the beneficiary has remained skilled

Failure to submit discharge bills creates an artificial gap in service on CWF and establishes a new benefit periods **inappropriately**.

Intentional failure to submit discharge bills for the purpose of creating a new benefit period is fraud.

CODING

Type Of Bill - Part A Swing Bed

181 -Admit to Discharge
182 - First in a Sequence, Continuing Claim
183 - Continuing Claim
184 - Discharge Claim
180 - Non-covered Claim

Billing Requirements For HCPCS/Rate (FL 44)

- When billing for accommodations, code your **customary charge** in the FL 44.
- When billing revenue code 0022, code the HIPPS code in FL. 44
- **Part A inpatient** claims do not require HCPCS codes for ancillary services.

SB-PPS Field Requirements
- HCPCS
- Service date
- Units
- Total charges

Billing Requirements For Service Date (FL 45)

- Required field on revenue code 0022 line for reporting ARD
- No other revenue line requires a service date on a Part A claim

Billing Requirements For Units (FL 46)

Revenue Code 0022

- When billing HIPPS codes and accommodations, units are **covered days**

- When billing HIPPS codes **without accommodations**, units represent days covered by a specific assessment

Therapy Ancillary Services

- When billing therapy ancillary services, **units represent number of times therapy procedures were performed**

- When there is no specific time frame to be reported for a therapy ancillary (for example, a therapy evaluation), the number 1 must be coded in the units field

Billing Requirements for Charges (FL 47)

- Required on all revenue code lines except 0022 (PPS code) and 0180 (LOA)

    - Report zero charges on revenue code 0022 and 0180 lines

Requirement To Split-Bill Claims

Due to the coding changes required by SB-PPS, it will be necessary to "split bill" ongoing services for the beneficiary in a Part A stay

- Split bills are required at the time the facility begins PPS billing (at the next cost report year on or after 07/01/02

- Split bills are required each year when the reimbursement rates are adjusted (10/01/XX)

- At the end of the provider's fiscal year

THERAPY EDITS

Edits For Therapy Ancillary Charges

Therapy Ancillary Edits
- Required if billing any of the RUG-III rehabilitation groups
- Ultra high rehabilitation groups require two therapy ancillary revenue codes on claim
- All other rehabilitation. groups require one therapy ancillary on claim

The SNF PPS and SB-PPS requires the billing of ancillary charges for residents who are classified into a RUG-III rehabilitation group.

System edits have been developed to ensure that the rehabilitation RUG-III groups are not billed unless therapy ancillaries appear on the claim.

- Residents in the highest rehab groups (RUA, RUB and RUC) require ancillary revenue codes for two therapy disciplines

- Residents in the lower rehab groups (RLA–RVC) require ancillary revenue codes for one therapy discipline

- Claims that fail system edits will be returned to the provider for corrected submission

- Any claim billed with a rehabilitation RUG-III group (HIPPS code) of more than ten days without the presence of therapy ancillaries on the claim will be returned to provider

Therapy Processing Problems

Medicare does not require an OMRA be done unless all therapy has ended. When a resident in an ultra-high therapy RUG-III Group decreases therapy, there is no mechanism to obtain a new HIPPS code to reflect the lower level of service. Swing bed providers are **permitted** to use the RUG-III rehabilitation group code from the previous assessment until the next regularly scheduled assessment is due.

However, continued billing of an ultra-high rehabilitation HIPPS code without two therapy ancillaries to support the group will fail system edits.

Therapy Edit Problem
- Workaround

Workaround For Therapy Edit Problem

- Enter a single line of coding to represent the therapy which has been discontinued
  - 429 for discontinued PT
  - 439 for discontinued OT
  - 449 for discontinued ST
- Enter a unit of 1
- Enter charges of .01

Providers should **not** be using this "work-around" for the purpose of getting claims through the system when they have failed to do an OMRA. This workaround is only appropriate when there has been a decrease in the level of therapy services and the next regularly scheduled assessment is more than 10 days away.

REIMBURSEMENT UNDER SB-PPS

Medicare Part A claims will be run through a PRICER software program provided to the FI by CMS. The software contains the reimbursement amounts (rates) for each RUG-III group. In combination with the rate information from each individual provider file, the FI's computer will be able to calculate payment for each claim regardless of the number of different RUG-III codes present.

Reimbursement Data On Part A Claims

Reimbursement
- Separate calculation for each HIPPS code entered on a claim
- Co-insurance remains as is currently calculated
- Payment equals total of each HIPPS payment minus the beneficiary co-insurance responsibility
- Payment for ancillary services on claim is factored into HIPPS reimbursement

The RUG-III reimbursement rate will overlay the HIPPS code in FL 44 for each line of data submitted with a revenue code 0022. The total charges field will not be altered on any other line of data and total charges will go to the PS&R report as submitted by provider.

- Each RUG-III group on the claim will be calculated separately, then totaled to determine reimbursement

- Beneficiary co-insurance responsibility is calculated and subtracted from total reimbursement to establish the payment amount

- Part A ancillaries will **not** be separately reimbursed or "settled" through the cost report

Withholding Issues

The Medicare FI may create a withholding (of payment) for swing bed facilities in the following circumstances:

Withholding

Failure To File Cost Report By Required Deadline

- 100% withholding remains in place until cost report is submitted and accepted

Overpayment On Final Settlement

- 100% unless payment arrangements are made on amount of overpayment or if payment arrangements are not met

Failure To Submit Timely Credit Balance Reports

- Credit Balance reports must be submitted by the quarterly deadine

Adjustments

- Withholdings occur when an adjustment cancels an original claim.

- When the adjusted claim is finalized, the correct payment is restored

THE ADJUSTMENT PROCESS UNDER SB-PPS

Adjustments

The SB-PPS claim adjustment process has not been changed . Follow your normal procedures to adjust any claim in which data elements need to be corrected.

Provider Adjustments

- Adjustment claims are submitted with type of bill 187 for swing bed
- Condition code (D0 – E0) in FL 24 must be coded to provide reason for adjustment
- Remarks are required when using D8 and D9 as reasons for adjustments
- Provide cross-reference DCN of the original claim
- All adjustments to the MDS document must follow the MDS instruction manual
- If an adjustment to a SB-MDS document results in a RUG-III group that differs from the original billed on the Medicare claim, an adjustment to the previously processed claim must be done
    - D4 condition code is required
- Medically denied claims **cannot** be adjusted without specific permission of the FI processing the claim
    - Adjustments would only be approved to add missing ancillary charges or to change dates on the claim if the original claim had incorrect dates of service involving a discharge or "cut"

Intermediary Adjustments

- Alerts from Common Working File (CWF) regarding a change in benefit days may result in a full or partial adjustment
- Quality Improvement Organization (QIO formerly PRO) review may result in their request for our office to do adjustments
- Appeal decisions may result in a full or partial adjustment
- Medical Review decisions to adjust a RUG-III category may result in a full or partial adjustment
- Mass adjustments following a policy or reimbursement change may result in a full or partial adjustment

PART B IN A SWING BED FACILITY

Swing Bed Benefit Extends to Inpatient Part A Only

Part B Coverage in a Swing Bed
- Inpatient hospital Part B benefits
- Bill type 12X
- Hospital provider number

- Once a beneficiary is no longer eligible for payment under Part A, that beneficiary is eligible only for **hospital Part B ancillary services** as described in the HIM10, Section 288
- Claims are submitted using **the Hospital Bed Provider number** and coded with bill type 12X
- Services on a 12X type of bill require:
  - Line item date of service
  - HCPCS/modifiers
- Reimbursement will be based on **outpatient PPS methodology**

Claim Example: Part B Hospital Ancillary Claim

1 *Part B Claim after Part A Ends in a*

2

3 PATIENT CONTROL NO. 12346

4 TYPE OF BILL 121

5 FED. TAX NO.

6 STATEMENT COVERS FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
110102	111202					

12 PATIENT NAME: GULLIVER ROBERT

13 PATIENT ADDRESS: 400 S. SALINA ST SYRACUSE NEW YORK 13221

14 BIRTHDATE	15 S	16 M	ADMISSION 17 date	18 hr	19 type	20 src	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
09231932	M		110102	12	3	1	10	06	12346								

32 OCCURRENCE code	date	33 OCCURRENCE CODE	DATE	34 OCCURRENCE code	date	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN code	from	through	37
01	100902	35	1101								A
											B
											C

38

	39 VALUE CODES code	amount	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES code	amount
a						
b						
c						
d						

42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0279			1101	22	110 72		
0301		80051	1101	1	36 00		
0301		82565	1102	1	19 75		
0301		84520	1103	1	18 50		
0306		81001	1109	1	30 50		
0420		97010 GP	1101	1	22 00		
0420		97010 GP	1102	1	22 00		
0420		97116 GP	1112	1	22 00		
0001				29	281 47		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE	XXXXXX					

57 DUE FROM

58 INSURED'S NAME	59 P. REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
GULLIVER R.	01	987654321A		

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	OTHER DIAG. CODES 68 code	69 CODE	70 code	71 CODE	72 code	73 CODE	74 code	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436									436		

79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE code / date | OTHER PROCEDURE CODE / DATE

OTHER PROCEDURE code / date | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE code / date

82 ATTENDING PHYS. ID: B12345 GLIDDEN G

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS: *Part B Ancillary Claim*

85 PROVIDER REPRESENTATIVE X | 86

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450